elements more important to assessing value may improve these processes and contribute to giving a fairer access to appropriate treatments to patients.

PCN336
TRENDS IN END-OF-LIFE APPRAISALS AND RECOMMENDATIONS BY NICE FOR ONCOLOGY THERAPIES
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OBJECTIVES: The end-of-life consideration introduced by NICE in January 2009 allows extension of the upper limit of the cost-effectiveness thresholds beyond £30,000 per QALY for therapies that are indicated in patients with a short life expectancy and for small patient populations, with survival benefit of at least 3 months. The aim of this study was to assess the impact of the end-of-life considerations on the health technology assessment (HTA) recommendations for oncology therapies. METHODS: NICE single technology appraisals (STA) for oncology therapies published between 2009 and 2016 were assessed. End-of-life consideration, HTA outcome, incremental cost-effectiveness ratio (ICER) values and the availability of patient access schemes were extracted. RESULTS: A total of 53 STAs were identified during the study period and 20 appraisals/therapies met the end-of-life criteria. Maximum end-of-life consideration was introduced by NICE 38 STAs in 2015 recorded the minimum (2 each). Of the therapies meeting the end-of-life criteria, 13 received positive recommendations with the ICER values ranging from £31,800 to £58,590. Highest percentage of positive recommendations were reported in the year 2009 (100%), whereas no positive recommendations were recorded in 2013, which could be attributable to the high ICER values of the end-of-life therapies appraised in 2013 (£40,000 to £100,000). In 2014 and 2015 each, 50% therapies (2/2) received positive recommendations. Of the therapies offering 13 positive recommendations, 11 included patient access schemes by manufacturers. Unacceptably high ICER values followed by economic modelling issues leading to uncertain ICER values were major drivers of negative decisions. CONCLUSIONS: The use of end-of-life criteria for maximizing patient access remains suboptimal, as fewer treatments have met the end-of-life criteria in recent years. Also, increasing ICER values in end-of-life cancer appraisal has resulted in negative recommendations, access schemes by manufacturers may improve patients access to novel end-of-life oncology therapies.

PCN337
PAYER/HTA REQUIREMENTS IN METASTATIC BREAST CANCER
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OBJECTIVES: A key challenge for successful introduction of new drugs in metastatic breast cancer (MBC) is a high probability and health technology assessment (HTA) outcome across Europe. Thus, understanding of the MBC HTA landscape is essential. Identify key HTA elements. METHODS: An in-depth analysis of published HTA submissions in MBC over the last 5 years was conducted. In total, 96 HTA reports in MBC from 9 agencies were reviewed. Results: 38 HTA assessments for 8 drugs were selected for further analysis. The analysis focused on the submitted data and valuation by the different agencies. Outcomes were validated in an HTA expert meeting. RESULTS: Of 38 HTA assessments, 11 received a negative recommendation, 6 a positive recommendation, and 13 a positive recommendation with restrictions. The remaining 6 assessments were ongoing/did not provide a recommendation as yet. The majority of submissions included RCTs with PFS as primary endpoint and OS as secondary endpoint. HRQoL was not provided in 13/38 cases, with criticism in 8/38 cases. Some criticism was expressed regarding the logistics of HRQoL collection. The weight assigned to significance and incremental cost-effectiveness of OS differed between countries. Twenty-eight of 38 MBC HTA reports included a PE evaluation. The key uncertainty drivers for MBC HTA recommendations are: evidence for the diagnostic model, modelling methods and data used in modelling. Moreover, well-validated PE model and acceptable ICERs are important to gain favourable HTA opinion.

PCN338
PERSONALISED BREAST SCREENING: KEY DRIVERS OF COST EFFECTIVENESS
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OBJECTIVES: This study estimates the cost-effectiveness of personalised breast cancer screening compared to one-size-fits-all screening. Personalised breast cancer screening has been proposed to both improve outcomes and screening programme efficiency in a personalised screening programme frequency of mammography is varied based on women’s estimated risk of breast cancer. The Adapting Breast Cancer Screening Strategy Using Personalised Risk Estimation (ASSIST) project aims to establish the programme's econo
dies and strategies in personalised screening. As there is substantial uncertainty at this stage about several aspects of personalised screening the objective of this study is to assess the cost-effectiveness of the programme for women at different ages. METHODS: The model was a decision analytic model which compared one-size-fits-all screening with no screening. The model included the following endpoints: breast cancer screening and death from breast cancer (5 and 7 years). Initial univariate sensitivity analyses were performed. The model was developed in Microsoft Excel. RESULTS: The model found that the cost-effectiveness of personalised screening compared with one-size-fits-all screening was lower. The key drivers for cost-effectiveness were the frequency of screening and current practice was calculated as a cost-per-case-detected from a health service perspective. Uncertainty in the cost-effectiveness estimate is investigated using one-way sensitivity analyses of key parameters. RESULTS: The incremental cost-effectiveness ratio of a three risk stratification procedure over the base case was £153,639 per E50,617 per case-detected. Influential parameters were sensitivity of mammography, recall rate, cancer growth parameters and accuracy of risk estimation. CONCLUSIONS: A very simple stratification procedure may not be cost-effective. The optimal risk stratification for personalised breast screening will be investigated to determine whether this offers improvement in cost-effectiveness.

PCN339
ANALYSIS OF DIFFERENCES IN HTA REIMBURSEMENT DECISIONS OF STAGE IV (METASTATIC) BREAST CANCER MEDICATIONS ACROSS DIFFERENT COUNTRIES
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OBJECTIVES: Besides being associated with a negative impact on patients’ lives and a low 5-year survival rate[1], stage IV (metastatic) breast cancer is accompa
nied with high treatment costs. The objective of this research was to analyse recent HTA decisions on metastatic breast cancer of different national HTA bodies worldwide and investigate reasons for variances in their decision making. METHODS: Reimbursement decisions for metastatic breast cancer treatments across various national HTA bodies published between January 2013 and May 2015 were analysed. Factors such as variations in treatment guidelines, different disease mutations, specific HTA requirements and the lack of sufficient patients’ data were considered. Each HTA decision was analysed according to the following criteria: clinical value, survival benefit, price, ICER (where applicable), toxicity and life treatment changes were not compared with each other, but the HTA evaluation of each treatment was considered across the single countries. RESULTS: A review of 5 breast cancer medications recently assessed independently across 9 HTA authori
ties across 6 different countries showed that in total 15/21 evaluations were recommended with restrictions. The remaining 6 assessments were ongoing/did not offer reimbursement. Drugs with sufficient proof of clinical value were nationally reimbursed. Positive reimbursement decisions for all treatments were made in Germany and France, while NICE and SMC only gave negative opinions. Most common reasons for non
approvals or restrictions were “lack of cost effectiveness” and “lack of clinical value” in respectively 10 and 3 of the HTA submissions. CONCLUSIONS: HTA deci
sions for metastatic breast cancer treatments differ across countries, with some appearing to be more willing to reimburse medications. Clinical value was the most important decision factor for 5 countries, whereas cost-effectiveness was more relevant to the remaining 4 HTA bodies. With novel medications for metastatic breast cancer coming to market in the next years[2], certain criteria for HTA assessments might need to be re-defined.[1][http://www.cancer.org/cancer
org/BreastCancer/EmergingMetastaticBreastCancer.html

PCN340
TO WHAT EXTENT DO Payers’ ASSESSMENT OF CLINICALLY RELEVANT OUTCOMES ALIGN WITH CLINICIANS’ Ongoing?
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OBJECTIVES: Previous research has shown that the evaluation of improvements in outcomes that are meaningful for the patient, but the preference of payers on what change can be considered meaningful is not well-defined. Clinically relevant differences (CRDs) in outcomes and grading of their magnitude in oncology are being estimated by both European and US oncology societies (European Society for Medical Oncology (ESMO) and American Society of Clinical Oncology (ASCO)). This indicates a transi
tion from a focus primarily on statistical significant improvements (i.e., “is there a difference?”) in outcomes to the potential relevance of these improvements to payers (i.e., “does the difference matter to patients?”). The attitude of payers towards CRDs in oncology outcomes is not well-understood, with little guidance around oncology CRDs from payers. The objective of this study is to assess the alignment between payers and clinicians in their assessment of clinical and health benefit of oncology products. METHODS: Oncology products launched recently were evaluated using the approach suggested by ESMO and ASCO. For the same products, the payer decision was evaluated to establish the clinical and health benefit rating by NICE (UK), HAS (France) and G-BA (Germany). RESULTS: Not all products granted market approval have been evaluated by payers. The research showed that where they had been evaluated, payer prioritization of clinical benefit differed to that recommended by oncology societies. Furthermore, clinical benefit assessment, particularly regarding overall survival improvement, differed between payers themselves. CONCLUSIONS: Oncology societies are recognising the need to ensure consistent assessment and representation of the clinical benefit of new oncology products. Whilst payers often have guidance on how they assess benefit, this is often generic and applied across therapy areas. As a consequence, there is a need to provide structured approaches to the evaluation of outcomes in oncology between payers, which provides challenges and implications in drug development programmes for novel oncology therapies.

PCN342
RELATIONSHIP BETWEEN THE PREVALENCE OF CANCERS IN ENGLAND AND WALES AND THE PERFORMANCE OF TECHNOLOGY APPRAISALS
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OBJECTIVES: Cancer is the most common cause of mortality in England and Wales. This study investigated whether the number of technologies assessed by NICE for a specific cancer reflects its prevalence in England and Wales METHODS: 1-year